1 AUTHORIZATION TO SUBMIT DATA ELECTRONICALLY

Entities that wish to bill the Michigan Department of Community Health or otherwise submit data electronically must be authorized by MDCH. This section describes that process.

1.1 AUTHORIZATION TO PARTICIPATE

Application forms for authorization can be obtained from the following email address:

AutomatedBilling@michigan.gov

1.2 APPLYING FOR AUTHORIZATION

At least one completed **original** application and participation agreement (Figure 1-1, Billing Service Company Certificate) must be on file with the Automated Billing Unit.

STATE OF MICHIGAN

JOHN ENGLER, Governor

DEPARTMENT OF COMMUNITY HEALTH

LEWIS CASS BUILDING
LANSING, MICHIGAN 48913
JAMES K. HAVEMAN, JR., Director

BILLING SERVICE COMPANY CERTIFICATE

The Service Company certifies that all invoice information submitted by the Service Company to MDCH is a true and correct report of information received from the service company's enrolled providers.

The service company understands that payment and satisfaction of claims submitted by the service company to MDCH will be from federal and state funds, and that any false claim, concealment of material facts, or falsified data systems input may be prosecuted under federal and state law. Any variations between provider billing and service company automated input to MDCH will be considered the responsibility of the Service Company and will be considered grounds for removal from the Automated Billing Program.

_____
(Name of Authorized Representative - Print)

_____
(Signature of Authorized Representative)

_____
(Name of Service Company - Print)

_____
(Date)

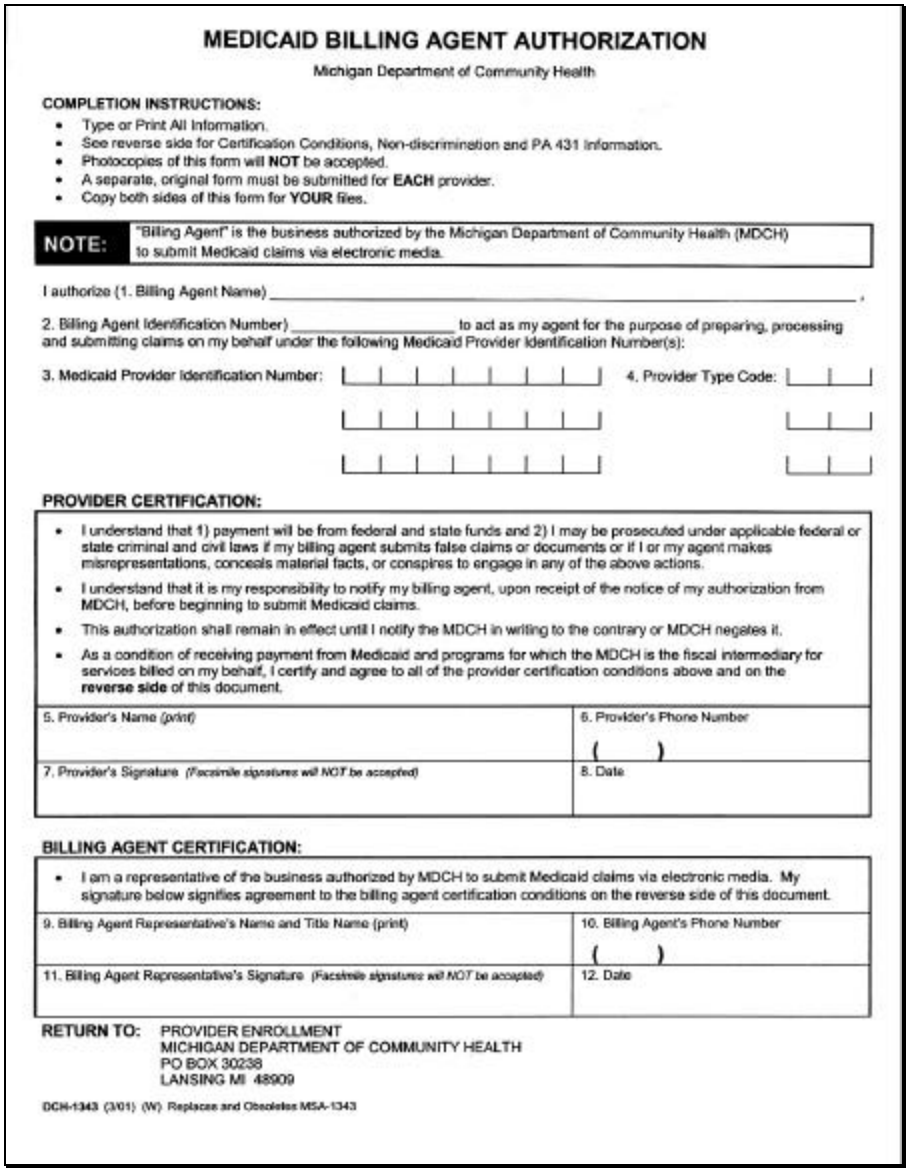
Figure 1-1: Billing Service Company Certificate

1.3 RECEIVING AUTHORIZATION

Once the systems test is successfully completed, a prospective electronic submitter will be notified that they can participate in the Automated Billing Program. The notification will specify the parameters that are unique to the submitter.

A Medicaid Billing Agent Authorization form must be completed by <u>each provider</u> authorizing the submitter to send bills or other data on a provider's behalf. Electronic submitters must have each provider they represent submit the Medicaid Billing Agent Authorization (DCH-1343 (3/01)) form (see Figures 1-2 and 1-3) immediately after they are notified of a successful systems test. A DCH-1343 must be sent to MDCH by each provider the submitter serves or by each provider who is new to a submitter. This form certifies that all services the provider has rendered are in compliance with Medicaid's guidelines. A copy of the form may be obtained from the Provider Enrollment Unit at the address noted in Section 1.4.

Only one electronic submitter per provider will be authorized to submit the provider's claims electronically. The provider's most recently authorized electronic submitter will be considered the only allowable agent to prepare claims electronically. **Authorizations remain effective unless otherwise indicated in writing by the provider**.



MEDICAID BILLING AGENT AUTHORIZATION

Michigan Department of Community Health

COMPLETION INSTRUCTIONS:

- Type or Print All Information.
- See reverse side for Certification Conditions, Non-discrimination and PA 431 Information.
- Photocopies of this form will **NOT** be accepted.
- A separate, original form must be submitted for **EACH** provider.
- Copy both sides of this form for **YOUR** files.

NOTE: "Billing Agent" is the business authorized by the Michigan Department of Community Health (MDCH) to submit Medicaid claims via electronic media.

I authorize (1. Billing Agent Name) _____,

2. Billing Agent Identification Number) _____ to act as my agent for the purpose of preparing, processing and submitting claims on my behalf under the following Medicaid Provider Identification Number(s):

3. Medicaid Provider Identification Number: | | | | | | | | 4. Provider Type Code: | |

PROVIDER CERTIFICATION:

- I understand that 1) payment will be from federal and state funds and 2) I may be prosecuted under applicable federal or state criminal and civil laws if my billing agent submits false claims or documents or if I or my agent makes misrepresentations, conceals material facts, or conspires to engage in any of the above actions.
- I understand that it is my responsibility to notify my billing agent, upon receipt of the notice of my authorization from MDCH, before beginning to submit Medicaid claims.
- This authorization shall remain in effect until I notify the MDCH in writing to the contrary or MDCH negates it.
- As a condition of receiving payment from Medicaid and programs for which the MDCH is the fiscal intermediary for services billed on my behalf, I certify and agree to all of the provider certification conditions above and on the **reverse side** of this document.

5. Provider's Name *(print)*	6. Provider's Phone Number ( )
7. Provider's Signature *(Facsimile signatures will NOT be accepted)*	8. Date

BILLING AGENT CERTIFICATION:

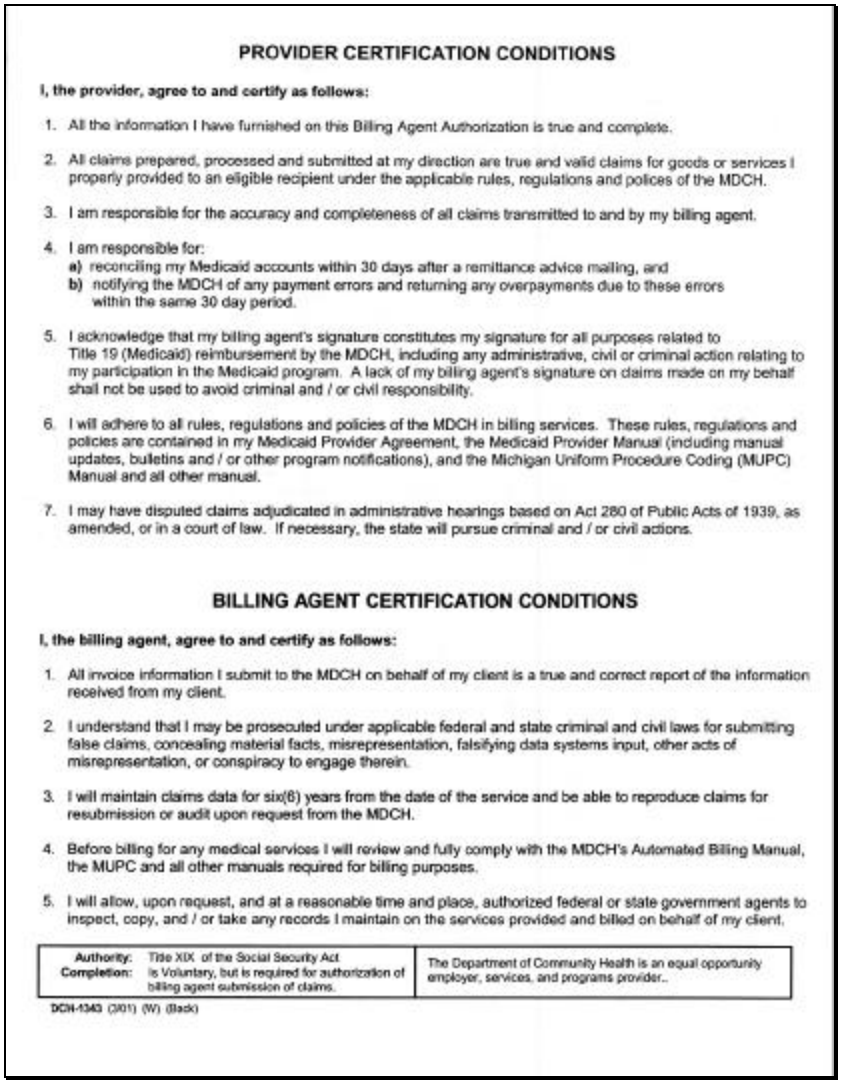
- I am a representative of the business authorized by MDCH to submit Medicaid claims via electronic media. My signature below signifies agreement to the billing agent certification conditions on the reverse side of this document.

9. Billing Agent Representative's Name and Title Name (print)	10. Billing Agent's Phone Number ( )
11. Billing Agent Representative's Signature *(Facsimile signatures will NOT be accepted)*	12. Date

RETURN TO: PROVIDER ENROLLMENT
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30238
LANSING MI 48909

DCH-1343 (3/01) (W) Replaces and Obsoletes MSA-1343

Figure 1-2: Medicaid Billing Agent Authorization Form (DCH-1343) for Providers to Submit Data Electronically to MDCH (Front)



PROVIDER CERTIFICATION CONDITIONS

I, the provider, agree to and certify as follows:

1. All the information I have furnished on this Billing Agent Authorization is true and complete.
2. All claims prepared, processed and submitted at my direction are true and valid claims for goods or services I properly provided to an eligible recipient under the applicable rules, regulations and polices of the MDCH.
3. I am responsible for the accuracy and completeness of all claims transmitted to and by my billing agent.
4. I am responsible for:
   a) reconciling my Medicaid accounts within 30 days after a remittance advice mailing, and
   b) notifying the MDCH of any payment errors and returning any overpayments due to these errors within the same 30 day period.
5. I acknowledge that my billing agent's signature constitutes my signature for all purposes related to Title 19 (Medicaid) reimbursement by the MDCH, including any administrative, civil or criminal action relating to my participation in the Medicaid program. A lack of my billing agent's signature on claims made on my behalf shall not be used to avoid criminal and / or civil responsibility.
6. I will adhere to all rules, regulations and policies of the MDCH in billing services. These rules, regulations and policies are contained in my Medicaid Provider Agreement, the Medicaid Provider Manual (including manual updates, bulletins and / or other program notifications), and the Michigan Uniform Procedure Coding (MUPC) Manual and all other manual.
7. I may have disputed claims adjudicated in administrative hearings based on Act 280 of Public Acts of 1939, as amended, or in a court of law. If necessary, the state will pursue criminal and / or civil actions.

BILLING AGENT CERTIFICATION CONDITIONS

I, the billing agent, agree to and certify as follows:

1. All invoice information I submit to the MDCH on behalf of my client is a true and correct report of the information received from my client.
2. I understand that I may be prosecuted under applicable federal and state criminal and civil laws for submitting false claims, concealing material facts, misrepresentation, falsifying data systems input, other acts of misrepresentation, or conspiracy to engage therein.
3. I will maintain claims data for six(6) years from the date of the service and be able to reproduce claims for resubmission or audit upon request from the MDCH.
4. Before billing for any medical services I will review and fully comply with the MDCH's Automated Billing Manual, the MUPC and all other manuals required for billing purposes.
5. I will allow, upon request, and at a reasonable time and place, authorized federal or state government agents to inspect, copy, and / or take any records I maintain on the services provided and billed on behalf of my client.

Authority: Title XIX of the Social Security Act **Completion:** is Voluntary, but is required for authorization of billing agent submission of claims.	The Department of Community Health is an equal opportunity employer, services, and programs provider..

DCH-1343 (3/01) (W) (Back)

Figure 1-3: Medicaid Billing Agent Authorization Form (DCH-1343) for Providers to Submit Data Electronically to MDCH (Back)

1.4 COMPLETING THE AUTHORIZATION PROCESS

An **original** (no photocopies) of the DCH-1343 must be completed by the provider according to the instructions on the form. The pink copy should be retained by the provider, the electronic trading partner ("billing agent") should keep the yellow copy, and the original should be forwarded to the following address:

Provider Enrollment Unit
MDCH
P.O. Box 30238
Lansing, MI 48909-7738

The provider will be notified in writing or by e-mail when the DCH-1343 has been processed. The provider must then notify the electronic trading partner to begin submitting claims on the provider's behalf. (Electronic submitters who wish to receive the notification directly should enclose a return envelope when they send in the form.)

Processing of the DCH-1343 takes approximately two weeks. If the provider does not receive a response to the DCH-1343 within four weeks, a new form must be submitted. A provider's claims prepared by an unauthorized electronic submitter will be rejected with explanation code 013 ("The invoice was submitted by Electronic File without authorization from the provider").

1.5 REVOKING AUTHORIZATION

The authorization to submit data electronically may be revoked at any time. The electronic submitter may reapply for participation and undergo another systems test.